Maniilaq Health Services Patient Comment/Complaint



We request this information so we may better serve you

Name:	Family Member:
Address:	Contact:
City/State: Zip:	Contact Phone:
Phone:	Chart #:
Gender Identity: Male Female:	Date of Birth:
Date Submitted:	Respond by:
This is a: Compliment Complaint Suggestion	
☐ Inpatient ☐ Outpatient ☐ Emergency Department ☐ Pharmacy ☐ Radiology ☐ Dental ☐ Eye Clinic ☐ Long Term Care ☐ Laboratory ☐ Registration ☐ Travel ☐ Village: ☐ Other: ☐ Other: ☐ Pharmacy ☐ Radiology ☐ Registration ☐ Other: ☐ Ot	
What is your desired outcome?	